Stacey Michelin, NP-FC
2269 Wilma Rudolph Blvd, Suite 106
Clarksville, Tn. 37040
P: 931-542-9010

Pharmacy_____ Phone #_____

Pharmacy Address _____

New Patient Registration Form

TODAY'S DATE_____

How did you learn about our practice? Physician (PCP)_____

Relative_ Friend_ Website__ Phone book__ Newspaper_ Other ____

Patient's Full Name _____ Age___

Home Address _____

City _____ State __ Zip _____

Home Phone Number _____ Mobile Phone Number _____

Emergency Contact Person _____ Emergency Phone Number _____

Emergency Person DOB _____ Sex M__ F__ Relationship to Patient_____

Patient's Email Address _____

Patient's Date of Birth _____ Social Security Number _____

Patient's Employer _____

If not employed is patient Retired? _ Student? _ Homemaker? _ Unemployed? _)

Patient Employer Address _____

City _____ State _____ Zip _____

Employer Phone Number _____ Extension ____Full Time_____ Part Time_____

Insurance Information

Responsible Party Information (Guarantor)

Who is Financially Responsible for the Account? The responsible party can never be a child.

Is the Responsible Party the same as the Patient information? Yes___ No_ (if no please fill in the information below)

Name _____

Address _____ City _____ State ___ Zip _____

Phone Number _____

Guarantor DOB _____ Social Security Number _____

Email Address _____

If patient is a MINOR, fill in responsible parent or guardian:

Patient/Guardian Name _____

Patient/Guardian Address _____ City _____ State ___ Zip _____

Patient/Guardian Phone Number _____

Patient/Guardian Email Address _____

I acknowledge the above information is correct and I accept financial responsibility

For any services offered for my dependent or myself.

Signature _____ Date _____

Identification Verified: Initials: _____ Method: _____ (For Office Use ONLY)

Primary Insurance Information

Name of Primary Insurance _____

Primary Insurance Address _____

City _____ State ___ Zip _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Is the Patient the subscriber for the Primary Insurance? Yes ___ No ___

(If no, please complete this section.)

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____

Subscriber Name _____

Subscriber Address _____

Subscriber City _____ State _____ Zip _____

Subscriber Date of Birth _____ Sex M F

Subscriber Social Security Number _____Subscriber Phone_____

Subscriber Employer _____

Subscriber Employer Address _____

City _____ State _____ Zip _____

Subscriber Employer Phone _____

Secondary Insurance Information (if applicable)

Name of Secondary Insurance _____

Secondary Insurance Address _____

City _____ State ____ Zip _____

Insurance Phone Number _____

Policy Number _____ Group # _____

Subscriber Relationship to Patient (circle one) SELF SPOUSE CHILD OTHER _____

Subscriber Name _____

Subscriber Address _____

Subscriber City _____ State _____ Zip _____

Subscriber Date of Birth _____ Sex M F

Subscriber Social Security Number _____ Subscriber Phone_____

Subscriber Employer _____

Subscriber Employer Address _____

City _____ State ____ Zip _____

Subscriber Employer Phone _____

NO known drug allergies. YES NO

Are you allergic to contrast dye used for x-rays? YES NO

Are you allergic to latex? YES NO

IT IS YOUR RESPONSIBILITY TO KEEP UP WITH YOUR MEDICATION REFILLS. IF YOU ARE OUT OF MEDICATIONS, WE DO NOT REFILL MEDICATIONS OVER THE PHONE. YOU MUST MAKE AN APPOINTMENT TO SEE THE DOCTOR FOR REFILLS.

Patient Signature: _____ Date: _____

If Stacey Michelin, NP-FC prescribes you controlled substances, you CAN NOT receive pain medication from any other doctor. If you do, you will be discharged from the practice.

Patient Signature: _____ Date: _____

Who may be authorized to make/cancel appointments or receive information about your health?
_____ Relationship: _____
_____

Previous Primary Care Doctor:

_____

Pharmacy: Address:

_____

Financial Policy

Payment is required at the time services are provided unless other arrangements have been made in advance. We accept cash, personal checks, and VISA, MasterCard, and Discover credit cards. There is a $35.00 service charge for returned checks

INSURANCE

We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan or you have no insurance, payment in full is required at the time of service. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. You are responsible for any services not covered by your plan.

Proof of Insurance-- All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to the time of service. Insurance denials for termination of coverage will be automatically billed to you.

Co-payments and deductibles--All co-payments, deductibles and co-insurance must be paid at the time of service. Protection of your insurance benefits requires us to charge for, and you to pay for, all required co-payments, coinsurances, deductible and non-covered services.

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Missed Appointments

Missed appointments--Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require a 24-hour notice of cancellation to avoid a cancellation fee. The fee for a no-show appointment is $35.00. If you miss 3 appointments, or have continuous cancellations, you will be discharged from this practice.

Assignment of Benefits

I authorize payments of my medical services to Stacey Michelin, NP-FC and any services not covered by insurance company I understand that I am responsible for those charges.

I have read and understood the above information on insurance and missed appointments.

Printed Name: _____ Date: _____

Signature: _____ Date: _____

Stacey Michelin, NP-FC

2269 Wilma Rudolph Blvd, Suite 106
Clarksville, TN, 37040

(931)542-9010 (phone)
844-557-9435 (fax)

Memorandum: Controlled Prescriptions DATE: _____

I _____ understand that on being prescribed a controlled drug. I am subject to a urinalysis test at any time that Stacey Michelin, NP-FC deems necessary. If I fail to provide a specimen at the time of request I acknowledge that I will not receive the prescription and that I can be immediately discharged. **You also can only use one pharmacy.** If found that you are using more than one pharmacy, you will be discharged immediately.

Stacey Michelin, NP-FC

_____
PATIENT PRINTED NAME

_____
PATIENT SIGNATURE

COMPASSION CARE CLINIC
2269 Wilma Rudolph Blvd Suite 106
Clarksville, Tn. 37040
PHONE: 931-542-9010
FAX: 844-557-9435

Authorization to Release Information

I hereby authorize Stacey Michelin, NP-FC to (Initial Each One)

____Obtain documents/ information from the records pertaining to services received.

____Release documents /information from the records pertaining to services received.

____Receive imaging from hospitals, lab, and etc. regarding my care.

I understand that my authorization will remain in effect for one year from the date of signature and that the information will be handled confidentially in compliance with all Federal and HIPAA Laws.

I also understand that I may revoke the authorization at any time by written and dated communication if I feel there is something I don't want to be sent out by the George T. Clardy, MD.

MEDICAL RECORDS RELEASE

I authorize the release of any pertinent documents to my care to process any claims to the insurance companies by sending a duplicate of the claim.

I also give an authorization of release for information concerning my medical records to the following individual.

Name_____

Relationship_____

I have read and understood the above information
Printed Name: _____ Date: _____

Signature: _____ Date: _____